OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

Res. No.	Comment by:	Representing	Position	Comments
14	Deepak Kumar, MD	Self	Support, in part	Agree with the resolution but would like one addition. There should be a provision that if a provider is terminated then his patients will also have choice to terminate their insurance in mid-year and sign up with a new one. <u>RESPONSES TO DR. KUMAR'S COMMENTS:</u> Dr. Hsiung: Can you clarify what you mean by patients terminating their insurance? And signing up with a new ? insurance. Thanks! Dr. Zwiebel: If you could clarify your statement that would be helpful.
14	Alan Levy, MD	Self & as Chair of OSMA FTFSL	Support	The FTFSL supports the intent of this resolution to ensure network adequacy given specialty and regional disparities in insurance networks, insufficient updating of networks by insurance companies, and other issues that compromise patient access to adequate care within their insurance networks.
14	Susan Zwiebel, MD	Self	Support	For patients more severely impacted with certain social determinants of health, this is a very important resolution. I personally did a study this past year on children with autism and providers in my community and found it very difficult to find the information. I think this is a great resolution. The only issue I find is the budget. I am not sure supporting this resolution would take $50,000.
14	Brian Bachelder, MD	Self	Support with modification	No conflicts. Speaking for myself. Two problems. 1. Need to define "regional" since it could use only major Ohio cities and include surrounding rural counties that do not have adequate coverage for >1 hour drive one way. 2. In the last resolved there may be legitimate reasons for immediate dismal such as loss of Medicare/Medicaid privileges, or a loss of a medical license.
15	Jonathan Myles, MD	Self	Support	The law as it stands gives us one of the lowest floors in the nation for payment of OON services. We need to do better.
15	Ken Christman, MD	Self	Oppose	Be careful what we ask for. Tying commercial reimbursements to Medicare Fee Schedules is NOT something we want. The federal government should not have the right to dictate physician compensation. Furthermore, Medicare pricing is subject to significant changes over the years. Also, Medicare fee schedules are NOT equitable between specialties and even from one procedure to the next. There is a huge disparity of compensations that we should never accept, let alone

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				ask for. On the other hand, there are certain fee schedules that have been developed by commercial payors, but even these have been manipulated and cannot always be trusted. What is wrong with the free market? <u>RESPONSE TO DR. CHRISTMAN'S COMMENTS</u>: Sean Kirby, MD, Author of resolution and President of Ohio Society of Pathologists. As a sponsor of this resolution, thank you for taking the time to read and comment. I wanted to clarify the intent of this resolution. Ohio House Bill 388, signed into law at the end of 2020, already does what Dr. Ken Christman describes, using 100% of Medicare as one safeguard. Resolution #15 is an attempt to mitigate the detrimental effects of that law. Resolution #15 asks OSMA to lobby for changes that would preferably defer to the federal "No Surprises Act". Should such a change not be possible, an alternative Medicare percentage is only suggested in our resolution in order to prevent Ohio utilizing a benchmark that is the lowest in the country.
15	Eric Drobny, MD	Self	Oppose	While I believe the resolution is well intentioned, OSMA already has policy on Out-Of-Network (OON) billing (19-2020) that addresses the position of the organization on this topic. I was actively involved with the government relations team while working on HB 388 and all the other bills and amendments in the legislative arena regarding OON that were proposed over the past 4-5 years. The majority of elected officials were originally pushing to add a rate cap into Ohio law. These proposals would have used average contracted and Medicare rates to limit physician reimbursement for OON claims. In my role as the CFO of my EM group, this would have severely restricted my ability to negotiate reasonable contracted rates with insurers. The final version of HB 388 that passed into law includes a robust arbitration process, which the resolution does not mention, and is a process that is very favorable to independent physicians. While HB 388 is not a perfect bill, OSMA's government relations team fought to get physicians the best deal possible and continues to lobby the state legislature on this issue. At this time the resolution is not going to be impactful, and could potentially hurt other legislative initiatives OSMA will be fighting for on our behalf. I urge no adoption of this resolution. <u>RESPONSE TO DR. DROBNY'S COMMENTS</u>:

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				Sean Kirby, MD, Author of resolution and President of Ohio Society of Pathologists: Thank you for your comment. Please see my response to Dr. Levy below, as I greatly appreciate the work that went into improving Ohio OON solutions over recent years. The comparison to previous legislative efforts is not a useful practice today. Instead, the federal No Surprises Act is the standard to which our legislation should be compared. The federal law came into view prior to the passage of HB388. At that time, Senator Stephen Huffman, MD, who had been one of the primary champions of HB 388, suggested voting against HB388 (video link provided on last page of this document at 1:11:30). Our society is in agreement that federal law makes HB 388 superfluous, and also that the federal bill offers a superior method of determining payments and protecting provider contracting. This resolution would offer OSMA a chance to make up for the missed opportunity of joining voices with Senator Huffman.
15	Alan Levy, MD	Self & as Chair of OSMA FTFSL	Oppose	I would like to add some context to this resolution on the process OSMA went through while negotiating the provisions in HB 388 along with all the other bills and amendments on the topic of out-of-network billing for the past few years. First, OSMA has a very thorough process for formally discussing and ultimately coming up with positions on different legislative issues. Once a bill is introduced, the OSMA GR team presents it to the Focused Task Force on State Legislation (FTFSL), comprised of physicians of different specialties from all over the state. We discuss the bills and give the GR team direction on the specific issues. Then, we vote on OSMA's position on the bill in question. The recommendation from the FTFSL is then presented to OSMA's Council for final sign-off. Once approved by Council, the GR team lobbies to try to achieve the approved position. Second, the issue of surprise billing has been around the legislature for several years, starting as language in the state budget in 2019. That language was a flat rate cap that insurers would pay a physician for an out-of-network claim. OSMA opposed this language vigorously, but unfortunately the language passed despite our efforts. OSMA then advocated Governor DeWine and asked for a veto of the language and was ultimately successful. This prevented the language from becoming law. Vetoes are very rate and in my

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				time with OSMA, I have only seen us successfully be able to get them a handful of times. After the veto, the governor and House and Senate leaders asked for all sides to come together and try to come up with a solution to surprise billing. Most elected officials were still supportive of a flat rate cap in law for out of network claims – which the GR team continued to oppose. OSMA lobbied and met with elected officials for months trying to educate them and talk to them about the contracting issues independent physicians face. After months of negotiations with elected officials, discussions with physicians, physician specialty associations, the FTFSL and OSMA's council, the final version of HB 388 emerged. While not perfect, OSMA was able to able to get an arbitration system that will benefit physicians included in the bill. This was the first time in all the years of negotiating and debating this issue that there was finally support from elected officials on this process. My fundamental issue with Resolution 15 as presented is it underscores the years of work that went into HB 388, and although OSMA was not able to perfectly reflect current policy on surprise billing in the language, the compromise was necessary to avoid a much more problematic law from going into effect. The GR team worked with the FTFSL and OSMA Council through the entire process and only supported the final version of the bill in order to get the arbitration system included. I recommend we do not adopt the resolution and have our GR team continue to work through the regulatory process on implementation of this law and track the impact once it goes into effect January 2022. At that time, it will be easier to assess if changes need to be made to the law. <u>RESPONSE TO DR. LEVY'S COMMENTS</u>: Sean Kirby, MD, Author of resolution and President of Ohio Society of Pathologists: Thank you for the additional context. I am sympathetic and appreciative of the work that went into the compromises over HB 388. However, the amount of work put forth in the past should not justify settling for a subpar result today. By your own admission, the end result is not what OSMA and Ohio physicians would have wanted,

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				which is an idea supported by numerous consensus groups. If we needed this compromised solution to protect patients or avoid worse legislation, HB 388 would still be concerning for Ohio providers. However, that situation changed with the introduction of the federal No Surprises Act at the end of 2020. The reimbursement pathway in the national law does not rely on a "greater of" formula and does not tie reimbursements to Medicare. Allowing HB 388 to override that national legislation puts Ohio providers at a significant disadvantage in contracting and is not justified by the fact that a good deal of work was put into HB 388. To add additional context to the time period you've outlined, the Ohio Society of Pathologists has opposed many of the compromises suggested during that same 2 year period you have outlined and I will attach some links on the last page of this document. It should be noted that our recommendations are not specific to pathology and would stand to benefit all non-employed physicians working in hospitals.
15	Lisa Egbert, MD	Self	Does not support without modification	If this resolution is to move forward, I would request that all references to existing bills and the Ohio Budget process be removed from the Resolved clauses as this is our usual practice for our OSMA policy because policy will continue beyond the discussion surrounding specific bills and processes at the state level.
15	Susan Hubbell, MD	Self	Does not support without modification	I have reviewed the comments and discussed the issue with our GR team. I would like to offer alternative language as follows: RESOLVED, That our OSMA reaffirm policy 19-2020 Out-Of-Network Billing; and, be if further, RESOLVED, That our OSMA work through the regulatory bodies on both the state and federal levels on implementation of Out-Of-Network policies, including advocating to align the policies to the extent possible; and, be it further, RESOLVED, That our OSMA closely track all Out-Of-Network policies and their impact on physicians in Ohio by creating a working group comprised of OSMA members from different impacted specialties that will do quarterly reviews and analysis of the outcomes of the Ohio Out-Of-Network law and assess if any changes need to be made. Comment: Having been on the OSMA Council for the last 9 years, our government relations team has

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				worked hard to get satisfactory legislation through the Ohio legislature. We were not able to get everything that we wanted in the bill that was passed during the Lame Duck session. We DO need both Federal and State legislation on this issue as some insurances are regulated by the state and others by the Federal Government. RESPONSE TO DR. HUBBELL'S COMMENTS: Sean Kirby, MD, Author of resolution and President of Ohio Society of Pathologists: Thank you for the comment and feedback. I would encourage your thoughts on additional resolves to acknowledge that OSMA will work to revise laws that are not aligned with all aspects of their policy 19-2020. This effort is reasonable and expected, given the fact that OSMA supported legislation that conflicted with multiple aspects of their own policy and then missed the opportunity to make corrections, even as elected state officials who advocated for HB388 expressed misgivings about the bill in light of the federal law. Simply monitoring and reevaluating the situation after provider contracts have been compromised does not suffice.
15	Andrew Rudawsky, MD	YPS	Oppose	Existing OSMA Policy 19-2020 already accomplishes the goals of this resolution. The OSMA is already actively involved in out of network payment reform, and we are concerned that limiting payment to an arbitrary percentage of Medicare or deferring to Federal law would hamper their efforts. RESPONSE TO MR. RUDAWSKY'S COMMENTS: Sean Kirby, MD, Author of resolution and President of Ohio Society of Pathologists. Under legislation passed with OSMA support, payment is already tied to an arbitrary percentage of Medicare, which is the lowest being used in the country. It is absolutely not the intention of the authors to endorse that practice and we agree that the removal of a "greater of" formula entirely is preferred. Policy 19-2020 is well intentioned but OSMA failed to introduce much of it into the Ohio law. OSMA's efforts moving forward should include lobbying for revision of current laws that are directly in conflict with their policy, particularly since the landscape changed drastically since the compromises were made.
15	Robert Gurdak, MD (co-author)	OH Society of Pathologists, representative of OSMA	Support	The resolution aims to have the OSMA work to align the reimbursement mechanisms for OON services set forth in HB 388 with the recently passed federal law. The federal law will be much more favorable to all

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				specialties. To speak to the point of arbitration, resolution 15 does not ask for altering the arbitration process set forth in HB388 that is potentially important to all of us. I urge support of the resolution.
15	Lawrence Fanelly, DO	Self	Support	The OON legislation is a big step in the right direction, but has a serious flaw that includes using a 100% of Medicare rate for payment. The bill as it currently stands gives us one of the lowest payment formulas in the nation for OON services.
15	Lori Elwood, MD	Self	Support	I am strongly in support of this resolution. I have no financial interest other than security for the future of the medical community in the state of Ohio. Given passage of the federal No Surprises Act which protects patients from the sometimes devastating effects of surprise billing, our state law HB388 is no longer necessary. Furthermore, HB388 as it is written, was enthusiastically supported by members of the insurance industry. The state bill is clearly disadvantageous to providers relative to insurers. And the state bill is clearly disadvantageous to providers relative to the federal bill. Ideally, we can defer to the federal bill.
15	Susan Zwiebel, MD	Self	Support	In SUPPORT of this resolution. The Centers for Medicare & Medicaid Services (CMS) remain the largest payer for health care in the United States and covers 54 million beneficiaries. According to the Census Bureau, by the age of 2030, 20% of the population will be over the age of 65, and the Medicare population is expected to grow to over 80 million beneficiaries. Medicare funding is determined by each state and changes. This should be considered with support of a bill that reflects the lowest reimbursement in the nation. And an insurance which surely will decrease significantly in the next ten years. HB 388 also empowers insurance companies to decrease the median in-network rate to match the OON rate. The incentive for physicians to remain in contract with those insurers will be low, and vice versa.
15	Kelsey McHugh, MD President-Elect OH Society of Pathologists	Self	Support	Testifying as an individual in strong SUPPORT of this resolution. I have no personal financial interest, except ensuring that all Ohioans have access to quality healthcare. Benchmarking reimbursements (particularly, benchmarking to Medicare rates) incentivizes insurance companies to artificially drive down reimbursement rates, which disproportionately negatively affects rural hospitals and healthcare systems treating the underserved. This exacerbates

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				the well-documented financial struggles of these institutions, which, in turn, harms the patients that this bill ostensibly intended to help. Hence, we propose an amendment which mitigates these effects by, at the least, setting Medicare benchmark rates that are consistent with those adopted by the majority of states that have passed similar legislation; or alternatively--and more much ideally- - adopting a payment structure devoid of a relationship to Medicare rates altogether, such as the one enacted in the analogous federal law.
15	Lisa Egbert, MD		Does not support without modification	I again remind the authors and supporters of this resolution that resolutions should not specify specific bills or the Ohio Budget process. The OSMA will advocate for its policy principles. If there are specific principles that are not in our current policy, please speak to those in your resolves. <u>RESPONSE TO DR. EGBERT'S COMMENTS</u>: Sean Kirby, MD, Author & President of OH Soc. Of Pathologists. I apologize if the resolution as submitted, did not conform with this request, but I did not find the requirement in the submission guidelines. Perhaps a generic resolve that could be included in the policy would be that OSMA will work to immediately revise any current state laws to bring them into alignment with all aspects of OSMA policy 19-2020. I believe this would be in the spirit of the existing policy and OSMA's mission in general. Allowing multiple years of compromised contracting in the name of fact-finding is not.
15	Leonard Madoff, MD	Self	Support	I am for the OSP resolution requesting OSMA to modify its position on Ohio's out of network law. I am an individual Pathologist member of a single specialty group.
16	Deepak Kumar, MD	Self	Oppose	This is roundabout way of getting to single payor. The words in this resolution may appear innocuous but the result is the same. <u>RESPONSE TO DR. KUMAR'S COMMENTS</u>: Jonathan Markle, MSS member & co-author. Hello, my name is Jonathan Markle. I am a MSS member and a co-author of this resolution. First of all, I want to assure you that this resolution is not meant as a backdoor or sly way to get the OSMA to endorse single-payer. Rather, as the wording of the resolution lays out, we want the OSMA to be willing to consider ALL options, private AND public, to increasing

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				healthcare access to U.S. citizens. The goal is pragmatism, not dogmatism. Personally, I believe the OSMA needs to be pragmatic in this area to keep the future of America's physicians secure. There is a lot of anger that I (and you, I'm sure, as well) have seen in this country over barriers to healthcare. If a program like a public option were ever to be proposed and passed in this country, physicians who stood against it instead of being pragmatic with its crafting and implementation may be perceived as obstructionist, leading to the further degradation of the profession (we already see this a lot with scope of practice legislation). As myself and other physicians-in-training are going massively in debt for our education, we want to avoid a situation where our profession is perceived as obstructionist, and shunned as a result. To you and all others reading this resolution, please take myself and the other authors at our words when we say we are not trying to jam single payer down the OSMA's throat. Nor do we want solutions in the area of healthcare access to be limited to insurance (hence the inclusion of "evidence-based" language in the second Resolved clause). I do admit that the title of the resolution could have been better crafted to suit this goal, however. Please feel free to reach out with any questions you have!
16	Ken Christman, MD	Self	Oppose	STRONGLY OPPOSE this resolution, which wrongly assumes that medical insurance translates into medical care delivery. NOTHING is further from the truth. Payors erect numerous barriers to the delivery of medical care across, whether commercial or government funded. They erect network, prior authorization requirements, denials, etc., often delaying the delivery of urgent medical care, and often at the hands of ill-informed lay people who follow cook-book policies in order to enhance the corporation's financial interests. Furthermore, the medical care costs would drastically decrease without the "benefit" of these 3rd party payors. Could anyone write a resolution calling for decreased dependence on "medical insurers"? <u>RESPONSE TO DR. CHRISTMAN'S COMMENTS</u>: Jonathan Markle, MSS member & co-author. As I commented below on Dr. Kumar's resolution, I believe that we could have done a better job with this resolution's title to convey our intent. We do not want to limit the OSMA to any specific private or public

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				solutions to healthcare access; rather, we just want the OSMA to have pragmatism as its official policy. This is why we included the "evidence-based" clause in this resolution, and did not eliminate the goal of private partnerships toward this goal either. Please feel free to reach out with any questions you have!
16	John Corker, MD YPS Chair	YPS	Support	Despite others' editorial comments here, and with sincere respect to my colleagues, this resolution neither mentions nor implies an intent to establish a single payer health care system. To state otherwise is disingenuous, as the medical student authors have made their intent clear both in the resolution and in this virtual reference committee. This resolution suggests policy that is both inclusive and appropriately broad. It keeps all options on the table, and empowers our advocacy team to act in both our best interest and that of our patients. This policy does nothing to discourage market-based solutions, and its emphasis lies in promoting a path to universal health insurance coverage that is supported by evidence rather than political ideology. This is excellent policy that will position our OSMA as a leader in any future legislative efforts to expand health insurance coverage that has been proven to mutually benefit physicians and our patients (when compared to no coverage). We should all support this common sense expansion of our current policy on this vital issue.
16	C. Smith			I believe that we should just limit this resolution to the effect that we believe in a pluralistic approach to coverage.
16	Brian Foresi	Lead Author	Support	I would like to emphasize the point made by my co-author that this resolution is intended to broaden the scope of healthcare options for consideration. In no way do we intend to guide the OSMA's stance down one specific route for coverage. By broadening our pool of acceptable plans to consider, we will be able to make more informed choices by taking into account the benefits of various coverage options. I appreciate the deliberation on this resolution because this is an important topic under consideration, however I would like to assure those opposed that this resolution provides inclusivity of options rather than leaning our organization towards a particular side of the debate. Feel free to email me with any further concerns or to discuss the details of this resolution.
16	Susan Zwiebel, MD	Self	Oppose	First of all, thank you for addressing this. Lack of health insurance is the biggest public health issue that we face (in my opinion). Even issues such as underinsurance still are a big issue too. For people with ERISA health insurance, for example, pre-existing

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				conditions can still be excluded. Regardless, this is a federal issue, and not a state issue (from the legal aspect). I believe the policies that the OSMA has in place are sufficient.
16	Lisa Egbert, MD	Self	Oppose	I am concerned about the use of the term "evidence based" in relation to "solutions" seeking to achieve universal coverage. I would question how we would determine what might be "evidence based" when it would be difficult to do randomized trials to study these various solutions. "Evidence based" in medicine refers to appropriately weighted randomized controlled trials. I do not think this can be extrapolated to various proposed solutions to achieve universal coverage. This verbiage may in fact hamper our advocacy team because they would only be able to support future proposals with the appropriate "evidence" behind it.
17	Ken Christman, MD	Self	Support	Institutions can easily remove physicians for whom they no longer have any use by simply failing to renew contracts for whatever reason. This should not force a physician to move away, disrupting their family's lives, their own lives, etc. I would strongly recommend that the wording be altered in order to reflect that under no circumstances should these restrictive covenants be used, let alone enforced, whether or not for clinical reasons, or any other reason. Of course, physicians should never be employed in the first place. They should be entirely responsible to their patients rather than an employer who might have competing financial interests to the patients, something otherwise known as conflicts-of-interest. This is why law firms cannot be owned by non-lawyers: clients of the law firm might have conflicts with the "owners" of the law firm. Likewise, physicians should never be owned by non-physician groups.
17	Susan Hubbell, MD	Speaking for Authors	Support	No conflicts. We have had several excellent physicians in Lima whose contract with a hospital has not been renewed. That nonrenewal came after the physician started asking questions about reimbursement, hospital policy, and other non-clinical issues. They have been well respected individuals whose patient care was outstanding and who were and are respected by their referring physicians. Unfortunately they had restrictive covenants for 2 years and 50 miles from any office of the hospital. They did not want to leave Lima and our physician community did not want them to leave. OSMA already has policy against restrictive covenants which we want to reaffirm. Until we can get restrictive covenants removed, we definitely do not

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				feel that the restrictive covenants should be enforced when the hospital does not renew a contract.
17	Richard Ellison, MD			*AMA Principles for Physician Employment* (Link provided on last page of this document)
17	Chris Paprzycki, MD	District 1	Support	During my job search after training, I was surprised by the extreme nature of the language with restrictive covenants. Entire pages were dedicated to the legal enforceability of the covenant, such as, if Ohio ever deems this to be illegal or a judge were to overrule restrictive covenants, the physician agrees that they are still legally bonded. It is appalling. However, we already have strong policy regarding lobbying efforts against restrictive covenants. I think the second resolved is the most important part of this resolution. We MUST teach our graduating trainees to look out for this language in their contract negotiations and ensure that they fully understand the future implications. The Academy of Medicine in Cincinnati held a very successful contract negotiation event for Residents/Fellows (pre-COVID), and this may be reproducible at the state level. The topic of restrictive covenants and knowing your rights was a large topic of discussion. Great opportunity for a recurring virtual event to educate physicians before they enter contract negotiations.
17	Susan Zwiebel, MD	Self	Support	None provided.
18	Ken Christman, MD	Self	Support	The idea of differential payments for the exact same service to one entity over another is abhorrent. It is wasteful, and exactly what has driven physicians into employed servitude. They may not be able to survive economically under the diminished payments while their employers will be able to command much greater compensation simply based upon their status. The concept of price controls is terribly misguided, but the price controls applied differentially are an abomination. This practice is neither free-market nor collectivist, but rather, is the embodiment of fascism, where one part of the private sector is blessed, while another part of the private sector is punished.
18	Susan Hubbell, MD	Self	Support	No conflict. The same procedure or office visit is reimbursed differently depending on whether a physician is in private practice or working in a hospital system. One of the biggest differences is the facility fee that the hospital system can charge which can more than double the amount that the insurance

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				company pays for the same visit. Physicians in private practice pay for rent, staff, supplies, insurance, etc. but they get no reimbursement for those costs in contrast to the hospital which can charge a facility fee. That is not fair to the private practice physician.
18	Carl Wehri, MD	District 3	Support	This resolution references the OPPS (Outpatient Prospective Payment System) set up by Medicare a number of years ago, and the SOS (Site of Service Differential) similarly conceived by Medicare years ago. Both systems were designed to offset hospital expenses that otherwise were not adequately reimbursed at the time. But things have changed. Exempting the changes Medicare made in January 2021 with a re-definition of office Evaluation and Management (E/M) Codes, documentation requirements, and price adjustments tied to each, in the last 18 years, physicians have received a 6% increase in payments during a period of time when inflation was up 30%, and hospitals have received a payment increase of 50% or an 8-fold increase in payments compared to physicians. (taken from 2019 AMA Council on Medical Services Report) The OPPS has permitted the hospitals to charge significantly higher prices for work, that if done in a physician's office would garner only a fraction of the payment, even if the service was an identical one. As an example, if I performed an OV and an EKG on a patient and for arguments sake, I charged and was paid $100, the hospital would receive on average $360. Yes that's 3.6 times as much. And it gets worse, the same service for which I might be paid $100 by a commercial carrier (as commercial carriers are paying close to or below Medicare fees in our area) would be charged out to a commercial carrier at $1200. It's mind blowing and maddening. Site of Service Differential payments are big contributors to this payment fiasco, and need to be reined in. These large payment inequities permit the hospitals to lure doctors out of private practice, offer big salaries, and have contributed significantly to gargantuan increases in health care costs, and in our area many itinerant physicians. The last administration tried to put a stop to it, but was promptly sued by the American Hospital Association, it's currently still tied up in the federal court system.

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

18	C. Smith			This system not only is killing private practice, but is also increasing the cost of medical care and limiting patients' access to providers as networks tighten.
19	Rajiv Patel, MD (Author)	District 1	Support	This Resolution stems from Takeback payments by insurance companies occurring unbeknownst to the Practice and over a several year period (2-5 years) from the dates of service. The insurance company was unable to demonstrate notification to our practice and upon inquiry, they were unable to determine why the takeback had occurred. They did not reconcile the item and no adjustment was made. This demonstrates the insurance company's ability to access your account to withdraw funds at their will and certainly exceeds the usual and customary authorization to the lockbox. Hospitals systems and Private Practice providers should be weary of these practices and safeguards need to be placed to prevent from this type of overstepping access. This has tax implications and reconciliations actions that require an inordinate amount of time to address and alter. In the second resolved, the 180 day deadline should be 90 days. I am the author of this resolution and have no conflicts of interest with its content. I am speaking in SUPPORT of this Resolution on behalf of District One. <u>RESPONSE TO DR. PATEL'S COMMENTS</u>: Ingrid Hsiung, MD. Thanks for submitting this resolution. That's terrible about what happened to your practice (and probably happens more often than it should to other practices too). Were there any other relevant policies you found for Insurance Takebacks? The prior policies included in this resolution seem more about reimbursement and payment.
20	Karen King, MD OSMAPAC Board Chair	OSMAPAC Board	Oppose	Statement of the OSMAPAC Board of Directors Regarding OSMA Proposed Resolution 20-2021: Minimum Requirements for Endorsement of Civil Servants March 8, 2021 The Ohio State Medical Association Political Action Committee (OSMAPAC) fights for Ohio physicians by helping to elect state and federal candidates based on their commitment to physician and patient issues. The OSMAPAC Board of Directors welcomes and encourages interest, support, and participation by the

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				OSMA membership and Ohio physician community in the activities of the OSMAPAC. As the political voice for the OSMA's physician, resident and student members, the OSMAPAC makes endorsements each election cycle. The endorsements process is comprehensive and inclusive. The OSMAPAC never makes an endorsement recommendation based solely upon any one single issue or principle, but rather based upon a complete review of all relevant information concerning a candidate. The candidates in each election are subject to thorough scrutiny by all individuals involved in the endorsements process, and several criteria are key for consideration: · Candidate's philosophy on medical issues; · District demographics and a candidate's ability to win; · Recommendations from local OSMA members; · Candidate's completed OSMAPAC candidate questionnaire, if applicable; and, · Candidate's interview with local physicians, if applicable. OSMAPAC's confidential questionnaire, which is sent to the campaigns shortly after the conclusion of the primary elections, asks candidates to respond to a variety of prompts that address important issues facing Ohio's healthcare landscape. Answers to the questionnaire are kept confidential to encourage the candidates to participate and provide their genuine, specific perspective regarding the topics they are asked to discuss. The recommendations for endorsements originate from the local physicians who have reviewed information related to the above criteria and in many cases, conducted interviews with both candidates. OSMAPAC often partners with local and county medical societies to help organize and carry out the interviews for candidates in each respective area. This past year, due to the circumstances concerning the COVID-19 pandemic and social distancing measures, all interviews were conducted virtually rather than in-person. After the recommendations from each local area or district are made, the OSMAPAC Board of Directors (which includes physicians from the 8 OSMA districts across the state, as well as representation from the OSMA's resident and medical student sections, and international medical graduate and OSMA Alliance

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				representatives) is tasked with the final approval of the endorsements based on the recommendations given to the Board by those local physicians. To enact OSMA policy which would alter the OSMAPAC's endorsement considerations in a way that would lead the endorsement decision to hinge so firmly upon any single issue as Resolution 20-2021 proposes to do, would not only severely undercut the deliberative and thorough review that currently takes place, but sets a worrying precedent that could pose a threat of further limiting the breadth of the process in the future. It is not just important, but essential that members of the OSMA and their consideration of the candidates campaigning in the areas of the state where those members live and work serve as the primary force that drives the endorsements recommendations. That is why the process used by the OSMAPAC for many years and in many election cycles, is already designed for such input to be developed into those recommendations made to the Board for approval. The OSMAPAC Board believes that Resolution 20-2021, while well-intended, would have a deeply troubling impact upon the OSMAPAC's endorsements process, and as an extension of this, negatively impact the ability of the OSMA to build meaningful relationships with our elected officials. We are concerned that having narrowed or singular criteria for selection of endorsements may cause candidates to bypass even seeking OSMAPAC endorsement, and preclude OSMA from engaging in important discussion about health policy with those running for office. This would, in essence, render OSMAPAC an ineffective political action force, and make it more difficult to progress toward our broader goals as an organization. The current endorsements process represents an invaluable opportunity for OSMA member physicians and OSMAPAC Board members to interact with our candidates for state legislative seats and other statewide positions before they are elected or re-elected. It is critical that we retain the capacity to fully review each candidate based on all of the factors described above in the endorsements process, including matters related to the pandemic, as OSMA has been and will continue to be highly engaged with the ongoing efforts in the state's COVID-19 pandemic response. We recommend that the OSMA House of Delegates move to Reject this Resolution as part of its 2021 policy actions.

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				In the event of questions OSMAPAC Board members from your district are available. Please send an email to info@osma.org with "Resolution 20" in the subject line, and a member from your district will respond. Karen King, MD OSMAPAC Board Chair Ryan Flynn, MD OSMAPAC Board, District 1 Jeffrey Studebaker, MD OSMAPAC Board, District 2 Carl Wehri, MD OSMAPAC Board, District 3 Jeffrey Harwood, MD OSMAPAC Board, District 4 John Bastulli, MD OSMAPAC Board, District 5 Denise Bobovnyik, MD OSMAPAC Board, District 6 John Stechschulte, MD OSMAPAC Board, District 7 Vivien Newbold, MD OSMAPAC Board, District 8 Deepak Kumar, MD OSMAPAC Board, IMGD Bradley Christoph, DO OSMAPAC Board, Resident Nick Mitchell OSMAPAC Board, Medical Student Kathy Harter OSMAPAC Board, OSMA Alliance
20	Elizabeth Muennich, MD	District 1	Oppose	We feel that the heart of this resolution is from a concerned and compassionate place however, we feel like the process that the OSMAPAC board already goes through is extremely diligent and exceedingly through. Having personally been a part of the process for local candidate interviews, the endorsements for

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				candidates are bipartisan and inclusive. The exhaustive endorsement process is made to determine who we should support as a PAC based on hours of candidate interviews with multiple PAC members across the state. I would encourage the authors to become active with the PAC board and participate in these interviews to see a "behind the scenes" look at the process of endorsement. There are many hours of your time that you could donate to the PAC board to join in and see the process first hand. After this you will appreciate their monumental hard work and that this resolution isn't necessary.
21	Ken Christman, MD	Self	Support	STRONGLY SUPPORT the intent of this resolution, but note that there already exists policy which actually calls for legislation to provide physician payment for these expensive prior authorizations. Simply supporting physicians' ability to charge for prior authorizations is NOT sufficient, as the payors refuse to pay. There must be legislation to insist that these extra expenses be compensated for. Some payors are now demanding retroactive "prior authorizations"? How ridiculous can this get? Often, those prior authorizations are processed by those who have a rudimentary understanding of the English language, even less understanding of patient needs. These erections of impediments to the delivery of timely and cost-effective medical care needs to STOP.
21	Rajiv Patel, MD (Author)	District 1	Support	I am the author of this Resolution and have no conflict of interest with its content. The resolution outlines in detail the incredible difficulties in authorizing for patient care/procedures which in the end, I am concerned will deter care from being rendered that is necessary and appropriate. The systems are inherently and increasingly cumbersome and are an indirect way to thwart care and thwart payment for services to be or already performed. As a Private Practice physician, I am fully aware of how these systems are increasingly complicated to navigate and how frustrating spending 45 to 100 or more minutes of office staff time to advocate for patient care, sometimes longer that the care or procedure going to be performed. Even though most Physicians are reading this are employed and may be wondering how this effects them, let me explain. The authorizations are not likely being done for the Professional Fees regarding the care and effort on behalf of the physician and the authorizations by Hospitals are focused on the easier reimbursable claims regarding Hospital Charges. An Employed Physician's compensation and bonus structure is productivity

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				based. I was told by a major hospital's CEO that obtaining compensation for Physician Services is "peanuts" compared to billing for Hospital Charges with less effort and that they are tending to not bill for Physician Professional fees especially procedural based. I advocate that systemic changes need to happen in order for patient care and access to be simplified and secondly, that physicians are compensated for their work rendered toward patient care especially in a Hospital Employment Model.
22	Mary LaPlante, MD	District 5	Support	No Conflicts of Interest. When a physician writes a prescription for a limited quantity for many reasons. The reason for prescribing a limited quantity can include a desire to make sure a psychiatric patient has only a limited number of pills at a time. When a physician writes a limited quantity of a medication, that prescription should be honored regardless of their reason.
23	Deepak Kumar, MD			Just FYI… This does not apply to Residents who have a full active medical License. This problem only applies to those residents who are on restricted resident training medical license. By law these physicians are only practicing under supervision in their program.
23	John Corker, MD YPS Chair	YPS	Support	Residents across specialties have expressed the need direct access to OARRS. It allows them to streamline their workflows and ensure that all prescriptions for patients are as safe as possible. Especially in my own specialty of emergency medicine, point of care access to OARRS allow residents to safely evaluate patient risk, treat symptoms appropriately and significantly increase throughput. This efforts is supported by both residents and the attendings with whom they work. <u>RESPONSE TO DR. CORKER'S COMMENTS</u>: Ingrid Hsiung, MD. Hi-thanks for submitting this. Clearly a problem if residents or fellows cannot access OARRS. At Cleveland Clinic, all the internal medicine residents with Training licenses have access to OARRS. Which specialties have you noticed are affected in addition to Emergency medicine? <u>RESPONSE TO DR. HSIUNG'S COMMENTS</u>: Alexander Pennekamp, DO. I believe that you have access-by-proxy in this situation. If you are using Epic for instance, you are accessing OARRS under your Attending's log in as a delegate. If you go to the OARRS website outside of Epic, you will be denied access.

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				The issue is that not all institutions use Epic (I cannot speak from this perspective). An issue at larger institutions is that an Attending / Program Director may only designate so many resident accounts. Delegate accounts are then divided over different Attendings, which may have little oversight with that resident anyway. The argument is that these are unnecessary barriers. Resident are very often those needing OARRS access in the first place, as we frequently need to review OARRS during intake and/or discharge workflows. These are also tasks completed by and large without Attending involvement anyway.
23	Alexander Pennekamp, DO		Support	Author Feedback: After attending the District 1 Resolution Discussion, I'd like to incorporate some feedback and make the following wording changes for clarification: 1. In the first Resolved: Replace, "Physicians in Training" with "Residents." This clarifies any confusion about expanding access to medical students, which is not the intent of the resolution. 2. Replace "any prescriber in Ohio" with "Residents." I would certainly welcome any friendly language changes offered by the Reference Committee. I have no personal interests, conflicts of interest or financial disclosures regarding the resolution.
23	Jeff Harwood, MD	Self	Support	Anything to streamline administrative burden. Given Dr. Kumar's comment maybe "Residents" should include "Interns" as Interns are not fully licensed but Residents can be if they apply after their first year of training?? But sounds like a great idea. Suspect pharmacy board doesn't want to deal with all the extra time-limited registrants.
24	Ken Christman, MD	Self	Oppose	Any death, while in-custody or out-of-custody is tragic. However, these circumstances are beyond the control and jurisdiction of physicians. Rather, they belong in the province of law enforcement and the judicial system. <u>RESPONSE TO DR. CHRISTMAN'S COMMENTS</u>: Hajera Afreen. Thank you for bringing this up. I mentioned within my resolution that the state of Ohio already considers racism a public health crisis under Senate Concurrent Resolution 14. We can't stop there. Racism is so prevalent and broadly incorporated in our society that simply recognizing it as a public health crisis has

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				no meaning unless individual aspects of it are singled out and addressed. As described within my resolution, the rate of arrests within the POC community exceed those in White communities, due to both heavy over-policing in Black and Latino neighborhoods and underlying racial discrimination against POC citizens. The full scope of arrest-related deaths is not even fully understood since law enforcement facilities do not ensure rigorous record-keeping of these incidences. Officers employing such violent tactics put the life of marginalized individuals at immediate risk and lead to needless deaths. Furthermore, incarceration itself takes both a physical and mental toll on those incarcerated. The environment in prisons deny proper sanitation and privacy, and as such, prisoners are more prone to acquiring infections, developing chronic health issues, and having mental depression and anxiety, all without adequate attention to their health needs. Prisons and the incarceration system display one of the clearest examples of health injustices and disparities. If physicians do not advocate for these issues, who will? Addressing the role of the prison-industrial complex in perpetuating racism is a crucial step towards developing health equity and one that this resolution seeks to take by further recognizing death in custody as a public health crisis. Please let me know if you have any additional questions!
24	C. Smith			I could only support the first resolution.
24	Andrew Rudawsky, MD	YPS	Support, in part	In support of R1 of this resolution. The State of Ohio has recognized racism as a threat to public health. While this is an essential first step, without meaningful data regarding all aspects of this threat it will be impossible to address. This resolution notes that there are large gaps in what data are collected regarding arrest- and custody-related deaths, and that these deaths disproportionately occur in POC. As stewards of public health in Ohio and practitioners of evidence-based medicine, we should support collection of accurate and complete data so that we can appropriately intervene.
24	Susan Zwiebel, MD	Self	Support	Again, thank you for bringing this up. Important topic. I acknowledge that death while incarcerated is a public health crisis. It is well known in the field of

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				public health that there are significant health issues such as privatization of prisons, rehabilitation of prisoners and systemic racism. There is evidence that the rate of incarceration is decreasing when comparing different races, however. That being said, the statement of "detrimental health effects of police custody" is something I would suggest removing. If the intent is to say "while under arrest" that would be clearer, although political. But as it stands, incarceration is a better statement and backed by evidence. RESOLVED, "OSMA acknowledges the detrimental health effects of police custody and incarceration as a manifestation of systemic racism within our criminal justice system."
25	Maneesh Tiwari, MD (Author)	Self & Co-Author Daniel Kim, MD	Support	OSMA has existing policy which broadly protects the coverage of medically necessary durable medical equipment and, of course, supports federal laws surrounding disability protections for Americans. Here, we wish to characterize durable mobility equipment (including wheel chairs, power wheel chairs, scooters) which we feel are a distinct entity within the broader umbrella of durable medical equipment. As stated in our resolution, 12.9% of Americans and 13% of Ohioans have durable mobility needs. The population of patients who require advanced mobility equipment such as power wheel chairs include those with spinal cord injuries, congenital disease, and traumatic injuries. These devices can be very literally lifesaving with regards to their ability to prevent falls and other secondary disability related injury. Further, they enable patients to regain quality of life, return to work, and independence. Although it may seem simple, physician level decision making to accurately evaluate a patient's mobility needs and determine the most appropriate make/model/specifications of mobility equipment requires the same level of expertise and experience that prescribing for instance, a medication to a patient requires. Adequate medical justification that is necessary for funding of said equipment is only one aspect out of many that are crucial to a successful outcome Despite their clear benefit to patients, mobility equipment can be very costly; furnishing these devices to patients in an affordable manner requires very precise documentation. Their value is under estimated and even with full approval, there can be a large direct cost to patients. State and Federal programs are often limited in how much aid they can provide as they lack direct provisions for mobility equipment. In summary, successful

OSMA 2021 Annual Meeting Resolution Committee Two
Online Testimony

				prescription of mobility equipment can be life changing for effected patients. However, the process can be challenging due to the complexity of available devices, cost, and obtaining approval/coverage/funding. We ask here that the OSMA acknowledge durable mobility equipment as an essential component of patient care and to advocate for policies which will reduce cost and increase access as it does with other indicated medical treatments.
25	Annamarie Beckmeyer, MSS Chair	MSS	Support	No conflicts or disclosures. We appreciate the authors bringing such an important issue to light. These devices absolutely impact an individual's ability to realize full health. Considering other states have enacted laws targeting mobility enhancing equipment costs (see West Virginia §11-15-91 exempting such equipment from sales & service tax), this seems like an appropriate area for the Ohio legislature to target and for the OSMA to take a stance on.
25	Brian Bachelder, MD	Self	Support, in part	No conflicts. Support except for the last resolved; who is to define "expertise" for prescribing the equipment. PCP's may not have "expertise" per say but can work through the requirements for prescribing the equipment. Such a requirement would have an adverse effect on the rural population resulting in the unintended consequence of making equipment more difficult to procure.

Resolution 15 – Dr. Kirby's links.

https://www.aans.org/-/media/Files/AANS/Advocacy/PDFS/Position-Statements/Out-of-Network-Consensus-Principles.ashx?la=en&hash=4682EEC89543BE1FEA2DE11BD82B3D18536A2C00

https://documents.cap.org/documents/final-osp-letter-to-house.pdf

https://pathology.osu.edu/osp/forms/OSP-Comments-HB-388-Oppose-May-5th.pdf

https://documents.cap.org/documents/dr-kirby-president-of-osp-testimony-in-opposition-to-h-388.pdf

https://www.ohiochannel.org/video/ohio-senate-insurance-and-financial-institutions-committee-12-9-2020

https://www.ohiochannel.org/video/ohio-house-finance-committee-12-11-2019

http://ohiochannel.org/video/ohio-senate-12-22-2020-part-2

Resolution 17 – Dr. Ellison's link to *AMA Principles for Physician Employment*

https://policysearch.ama-assn.org/policyfinder/detail/physician%20employment?uri=%2FAMADoc%2FHOD.xml-0-1535.xml